



## Medwork Independent Review

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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)*

**DATE OF REVIEW:** 8/15/2012

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Inpatient stay for L5-S1 anterior lumbar interbody fusion for lumbar spine (22558, 22845, 22851, 38220, 20930)

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Texas State Licensed MD Board Certified Orthopedic Surgeon & Spine Surgeon

**REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Texas Dept of Insurance Assignment to Medwork 7/30/2012
2. Notice of assignment to URA 7/30/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 7/30/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 7/30/2012
6. IRO review response 8/1/2012, medicals 8/5/2012, medical case information 7/26/2012, appeal determination 7/25/2012, appeal letter 7/25/2012, letter from TASB 7/25/2012, change assessment letter 7/25/2012, email 7/25/2012, letter from TML 7/11/2012, preauthorization 7/9/2012, authorization for surgery 7/9/2012, email 7/9/2012, letter from TML 6/24/2012, email 6/26/2012, preauthorization 6/25/2012, 6/4/2012, medicals 6/1/2012, preauthorization 4/24/2012,

**PATIENT CLINICAL HISTORY:**

The patient is a male with lower back pain in a mixed L5 and S1 nerve root distribution. The patient is status post L5-S1 laminectomy/discectomy in 2004. He has a body mass index of 36. He underwent a MRI on 1/10/2012 which reveals a protrusion at L5-S1 possibly impinging on the L5 nerve root. Epidural steroids were requested and approved on 3/6/2012. The results are unknown. There was a negotiated decision for approval of a CT myelogram. The formal interpretation suggests there is a retrolisthesis at L4-5 to what degree is not measured. It also references L1-2 motion. This again is not measured. The source of the patient's back pain is



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still undetermined. He has multiple levels spondylosis, questionable degenerative motion at the L4-5 level recently documented by a CT myelogram.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

This gentleman has had previous decompressive surgery from L4 to S1. He now has ongoing back and bilateral leg pain. He has been demonstrated to have a retrolisthesis of L4 on L5 with spondylosis at L5-S1. Using ODG guidelines, my opinion is request for surgery should be denied. Using ODG guidelines, this patient does not fulfill criteria requiring fusion. There is no indication that this man has demonstrated any quantitative or qualitative instability. There is no indication of flexion/extension films showing angulation or translation. There is documentation of a retrolisthesis above the indexed level.

This case does not fulfill criteria for surgery; therefore, the insurer's denial is upheld.

### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)